

IPL REFELCTIVE ESSAY

by Jean Didier Libouka

FILE	17994-1516_5580251_33383263_IPL_REFELCTIVE_ESSAY.DOCX (38.61K)		
TIME SUBMITTED	01-MAR-2016 12:03PM	WORD COUNT	4034
SUBMISSION ID	53599757	CHARACTER COUNT	21655

Leeds Beckett University
Faculty of Health and Social sciences

BSc (Hons) Mental Health Nursing
Personal Professional and Inter-Professional Practice(PPIP)
Inter-Professional Learning (IPL)

2015 - 2016

Level 6 Semesters 2

Assignment: Essay (3298Words)

'Demonstrate the application of professional, ethical and legal principles to one significant issue that a student has encountered in their current clinical practice.'

Introduction

The aim of this assignment is to reflect upon an incident that occurred during placement that required the understanding and application of ethical, legal and professional principles (Buka 2008, p. 20). The incident I shall discuss occurred in the Emergency Department acute psychiatric unit. A 48-year-old female patient, Mrs Pebble (her name has been changed for confidentiality reasons [Barker 2009, p. 469; Buka 2009, p. 54; NMC 2015]), was brought to the department by police. I have chosen to discuss the case of Mrs Pebble because it involves the police, section 136 of the Mental Health Act 1983 (amended in 2007 [MHA 1983; MHA 2007]), and actions taken by health professionals to avoid liability (Thomas & Moore 2013).

According to the NMC (2015, p. 15), nurses must hold a profound understanding of appropriate legal, professional and ethical standards for caring. Nurses are required to comply with strict ethical guidelines and work in accordance with the law of the country (NMC 2015, p. 15). The relationship between the law and ethics in nursing remains complex, but professional and ethical practices undertaken within the framework of the law are legally defensible (Thomas & Moore

2013). As nurses are frequently confronted with a range of complex dilemmas, those who lack a comprehensive understanding of ethics, professional guidelines and relevant legal frameworks may find themselves helpless, especially when questions related to their conduct arise.

To examine the intersection of law, ethics and professionalism in the case of Mrs Pebble, I will use the 'What?', 'So what?' and 'Now what?' model proposed by Terry Barton in 1970 (and subsequently expanded upon by John Driscoll [2007, p. 47]) (Buka 2008, p. 20). Driscoll's model is easy to use, and suitable for reflecting on this incident, identifying what I have learned from it, and for outlining the implications for present and future practice (Driscoll 2007, p.56).

What?

This stage helps identify and describe the incident that occurred (Driscoll 2007, p. 47). Mrs Pebble was escorted to the Emergency Department by police, who indicated that she was showing symptoms of disordered thoughts, impulsiveness and severe depression. She was subsequently referred for a mental health assessment. It was unclear to me whether she was detained under section 136 of the MHA 1983. The information on her referral sheet and that provided during the handover from the triage nurse made no mention of section 136; it only made reference to her arrest for impulsive driving on the motorway and failure to pull over on first police signalling. During the assessment interview with Mrs Pebble it became clear that she had left her residence after an argument with her husband. She did not return almost 24 hours. As a result, her husband called the police and declared her to be a missing person.

In Mrs Pebble's mental health state examination, it was noted that she was well dressed, kempt, coherent in her speech, possessed a good understanding of her situation and good orientation of place, time and people. She had poor appetite and a lack of sleep, but suffered no apparent hallucinations or psychotic symptoms (Castle & Bassett, 2010). The assessment revealed that Mrs Pebble had been going through emotional difficulties and issues with family dynamics. Her mother, whom she described as her best friend, had died less than a year earlier. Her older daughter, for whom she organised a costly wedding, divorced her husband after less than a year of marriage and was no longer in contact with Mrs Pebble. She also lacked support from her husband. Although the assessment showed that Mrs Pebble presented no risk to self or others, I was puzzled by the unilateral decision taken by the nurse to discharge her from hospital. Mrs

Pebble insisted that she felt fine and was happy to go home. The nurse read the plan and explained to Mrs Pebble that:

- she was being discharged
- in the case of relapse, she could call the emergency numbers on a pamphlet provided to her
- a letter of discharge would be written to her GP
- her husband would be contacted via telephone to inform him that she was returning home.

The plan made no mention of follow-up. However, it was obvious that she was being sent back to primary care, that is, to her GPs.

The nurse explained to me that she did not find any evidence of mental health impairments in Mrs Pebble that potentially put herself or others at risk (Hughes 2012). Given that the role of the acute liaison psychiatric services is to assess and signpost clients, they would not be legally bound to follow up with the patient once they had been assessed, discharged or referred to another service (Hughes 2012).

Mrs Pebble pleaded with the nurse to contact her husband and speak with him, as nobody would understand that she needed time to grieve. However, this was not seen as a priority and Mrs Pebble was discharged. The police officers who stood outside the door of the interview room while Mrs Pebble was being assessed were informed of the decision by the nurse, at which point they left.

The NMC code stipulates that, as a nurse, I am accountable for my actions in practice, and that I must be able to identify and manage risks to patients under my care. This means that I assess patients' needs, deliver or advise on treatment, and provide help, including preventive or rehabilitative care, on the basis of best available evidence (NMC 2015, p. 7). In Mrs Pebble's case, the hasty actions taken by the nurse to discharge Mrs Pebbles while she was still pleading for help were questionable to me, as she said she felt suffocated at home.

Carvalho et al. (2011, p. 10) indicated that nurses are supposed to possess good knowledge and skills that they apply to the planning and delivery of a high standard of care that responds to the needs of the service user. This means that it is not enough for a nurse to only know how to

perform the task competently. A nurse must also be able to explain why they have chosen that course of action (Carvalho et al. 2011, p. 15). For a nurse to make the right decision that meets legal standards, ethical standards and public expectations, she must first possess a good understanding of those standards and how they apply to her activities (Carvalho et al. 2011, p. 25).

In the following section, this essay will examine Mrs Pebbles case from three perspectives:

1. Legal considerations: was section 136 of the MHA 1983 invoked? If not, on what grounds did the police escort Mrs Pebble to hospital?
2. Professional considerations: this includes the risk assessment and management of a person with mental illness, and any follow-up.
3. Ethical considerations: this includes codes of conduct and factors involved in making ethical decisions.

So What?

The “So what?” question will prompt me to analyse and evaluate my feelings and discuss the effects of relevant actions (Driscoll 2007, p. 47; Driscoll 2010).

Although I obtained no information, but I assumed Mrs Pebble was arrested by the Police under section 136 of MHA 1983. Section 136 grants the police powers to remove a mentally impaired person from a public place and into immediate care in a place of safety, which may be a police station or hospital, for up to 72 hours (Mental Health Act/Department of Health, 1983). The police may do so only in the best interests of the patient and public safety, in order for that person to be assessed by a psychiatric professional, which may be a doctor or an approved mental health professional (AMHP) (DOH 1983; MHA 1983, s136). Only an AMHP or a doctor are able to decide whether the person has mental health problems that require arrangements for their care (DOH 1983; MHA 1983).

Due to inconsistencies in record-keeping and inaccurate information, it was not clear why Mrs Pebble was escorted or detained by the police (NMC 2015, p. 9). The police may have acted upon information from Mrs Pebble’s husband and on the basis of her past history with mental health services. However, at the time of her arrest Mrs Pebble presented no significant evidence of

disordered thoughts or agitation. She was detained because she allegedly drove impulsively, with the potential to harm herself or others.

The police officers' code of practice guidelines stipulates that the National Health Service (NHS) must be involved when a person is being detained under section 136 (House of Lords 2008). However, in the case of Mrs Pebble, the police did not involve the NHS for several hours, until they escorted her to the emergency department in the late evening. The standards for the use of section 136 indicate that it may be employed only if the person is at risk of harming self or others (Bindman et al. 2003). The Police may have assumed a 'fiduciary' responsibility, meaning that they preserved Mrs Pebble's health and welfare while they deprived her of her freedom. However, it is unclear whether her human rights were properly considered while in police custody, (Thomas & Moore 2013). Bindman et al. (2003), referring to the European Court of Human Rights concerning mental health, argued that 'lawful detention' must not be arbitrary, and that it demands a minimal therapeutic setting. Mental health must be defined through medical expertise and be assessed to be of a degree that would allow compulsory confinement. Prolonged confinement is valid only if the disorder persists (Bindman et al. 2003). However, Barker (2009, p. 600), referring to the Human Rights Act 1998, argued that a person of unsound mind can be detained as long as the procedures used are legal, meaning the person's private life can be interfered with for the protection of the life, rights and freedoms for others.

Thus, while the police action may have been conducted with good intentions, it could be described as false imprisonment, which means intentionally subjecting someone to confinement. That is, Mrs Pebble was deprived of her personal liberty for several hours without consent (Thomas & Moore 2013).

During Mrs Pebble's risk assessment, consent was first obtained. Bindman (2013) emphasises that healthcare professionals must obtain the patient's consent prior to any engagement where the patient has the capacity to understand the nature of the decision and has the appropriate information available to consent freely and without coercion. The Mental Capacity Act (2005) (MCA [2005]) is a legislative framework that helps mental health professionals determine whether the patient has the capacity to make decisions about therapeutic intervention. The statutory principles of the MCA (2005) stipulate that healthcare professionals must assume that any individual in their care has the capacity to make decisions regarding their care, ensuring the

patient has been offered every opportunity to be involved in the decision-making process. Mrs Pebble was able to absorb, retain and weigh the information given to her, and make a decision (Simpson 2010) before consenting to her assessment (Bindman et al. 2003). She clearly expressed that the only thing she wanted was to be given enough time to grieve rather than to feel 'suffocated' by family members.

Consent represents one of the crucial legal principles of nursing (Thomas & Moore 2013). The literature stipulates that prior to any therapeutic engagement with the patient, healthcare professionals undertaking an assessment or assisting a patient with care must obtain the patient's valid informed consent (Buka 2008, pp. 30, 71; DOH 2009). As Mrs Pebble sat comfortably in the interview room, the nurse introduced herself and myself, and explained to Mrs Pebble the purpose of the service to help her understand what was happening and to set the agenda (Castle & Bassett 2010). This was routine introductory practice. However, it was inappropriate as the patient was not asked whether she wanted to be assessed or whether she was happy with the information given, as consent is continuous (Barker 2009, p. 626).

The law views a patient's integrity with high regard, meaning that people have the right to know what is going on with their body, and to be fully involved in the decision-making process concerning their care (DOH 2009). This means the patient must be given the opportunity to consent, or agree with any suggestion, regarding their care prior to any intervention (Simpson 2011). Their choices and wishes should be identified and considered (DOH 2009), as consent remains crucial to uphold the patient's right to autonomy and to provide a sound legal defence for the healthcare professionals (Taylor 2013). However, Buka (2008, p. 30) questioned how much information needs to be disclosed to the patient before consent can be said to be informed. Buka (2008, p. 30) argued that merely disclosing information to the patient is not enough. Consent can be either implied or expressed. In the case of Mrs Pebble, she understood the information about the services, but she did not express in any way that she wanted to go on with the intervention. She sat and listened without being coerced to do so. Consent should be given freely without coercion by a patient who is deemed to have the capacity to do so (Taylor 2013).

The interview lasted approximately half an hour, then the nurse unilaterally decided that Mrs Pebble was free to go home. The nurse insisted that she did not see any evidence that Mrs Pebble

intended to harm self or others. In private, I asked the nurse whether it was safe for Mrs Pebble to go back so soon after she had fled her home.

According to Yeandle et al. (2013), people with disordered thoughts or personality disorders often present high risks to themselves or others. Yeandle et al. argue that the non-collaborative approach to risk assessment and management can lead to the management of risk being seen in isolation as something done to the patients, rather than in the context of a patient's own strengths and experiences (Yeandle et al. 2013). I felt I had no say in the matter. I was delegated by the nurse to record the assessment interview and to write it up in the data format system, meaning I was more concerned with listening and accurately recording the conversation (NMC 2015, p. 5). I needed to take the patient's history, risk assessment and mental health examination from the patient's interview conducted by the nurse. I was learning to take psychiatric histories and to proceed with a mental state examination (Hughes 2012).

Regarding professionalism, the NMC (2015, p. 7) stipulates that the nurse should 'uphold reputation of their profession at all times, and display commitment to the standards and behaviours set in the code'. Considering Mrs Pebble was emotionally unstable and was previously known to the mental health services through a diagnosis of depression and anxiety disorders, it would have been appropriate to collaboratively explore with Mrs Pebble, and the team and share understanding of acute and dynamic risks and protective factors (Yeandle et al. 2013).

The risk assessment was conducted in a private and safe environment, maintaining both confidentiality and comfort of the patient (NMC 2015, p. 6). The risk assessment was based on the presenting complaint, a mental health examination and past history (personal and family) (Hughes 2012). I still believe patient's best interests were not fully ensured, because of the nurse's unilateral decision. Simpson (2011) emphasises every effort must be made to determine what would be beneficial for the patient.

There are also ethical considerations. The nurse's decision may have been influenced by patient's capacity; the nurse's judgement regarding what was the right and wrong courses of action was influenced by the patient's own capacity to decide for herself (Buka 2008, p. 16).

The patient used her autonomous rights to influence the decision to go home (Buka 2008, p. 29). However, the NMC (2015, p. 11) urges nurses to preserve patient safety and public safety by working within the limits of competence; the nurse must exercise a professional duty of candour and immediately raise concerns when a patient presents a risk to self or others, and take the most appropriate course of action.

Regardless of the discrepancies, I still believed that the nurse's decision was largely underpinned by the four ethical principles suggested by Beauchamp and Childress (2001), which comprise beneficence, respect for autonomy, non-maleficence and justice.

The principle of beneficence was implemented by the nurse. The balance between benefits and the risks for the patient was relatively evaluated. Sound advice was given, including emergency contacts in the event of a relapse (NMC 2015, p. 5). As I was not convinced discharge was in Mrs Pebble's best interests, I asked the nurse what made her believe that Mrs Pebble would benefit from going back home at this moment, and why she did not discuss the decision with the team. The nurse responded by asking me, 'Where did you want to send her?' The NMC (2015, p. 8) urges nurses to work collaboratively with colleagues to preserve the safety of those receiving care.

Non-maleficence, also known as 'nocere', which in Latin means 'to do no harm', was assured. The nurse and I possessed the obligation to preserve patient's safety and to cause no harm. Mrs Pebble was fully involved in the decision-making process and given all the options available in the discussion of her care (NMC 2015, p. 5). This means patient's rights and autonomy were respected. Though the eventual decision taken to discharge her was unilateral in terms of there being no discussion with the team, Mrs Pebble was involved. The literature indicates that any

therapeutic intervention involves some elements of harm, but this should not be disproportionate to the benefits (Beauchamp & Childress 2001).

Now What?

This stage of the model is concerned with future outcomes, what I have learned and how I can apply what I have learned (Driscoll 2010). It will guide me to synthesise and consider the implications of actions (Driscoll 2007, p. 50).

Having explored the legal, ethical and professional dimensions related to the risk assessment carried out on Mrs Pebble, it has shown the importance of these considerations and has helped me understand what actions as a nurse I should take when I face a difficult situation where my judgement is needed (Barker 2009, p. 612). This experience has benefited me, and will have an impact in my practice in various areas, particularly in my ability to clearly communicate information using terms easily understood by colleagues and the public, and my commitment to respecting people's rights and autonomy (NMC 2015, pp. 6–7). I had doubts concerning the nurse's decision to send Mrs Pebble home while she was still going through a period of anxiety and distress, and I attempted to advocate for Mrs Pebble; however, I am well aware that nursing practice must be evidence-based (Thomas & Moore 2013).

I still think that I would have referred Mrs Pebble to a community mental health service for further support, and counselling on grief and bereavement, passing the patient into the responsibility of an appropriate service. Barker (2009, p. 365) emphasises that people who have lost loved ones need to talk to someone who can understand them, as they may feel hurt, puzzlement or despair. Barker (2009, pp. 365–366) argues that it is the role of the nurse to find ways to help the person talk about their loss.

As a nurse I will need to develop my level of competency by equipping myself with the skills to challenge existing practices and evaluate my role in clinical settings, as I am likely to meet patients with complex healthcare needs. I have to continue to develop my awareness of the importance of strong evidence bases, of my responsibilities in prioritising patient care and working collaboratively with others (NMC 2015, pp. 4–7). I must also maintain nursing's core values, particularly the 6Cs (Stephenson 2014). I have learnt about the legislation governing

nursing, which includes the MHA 1983, the Mental Capacity Act 2005 and other statutes, that help guide decision-making in the patient's best interests (Carvalho et al. 2011).

Conclusion

Risk assessments of mentally ill patients present huge challenges in terms of ethical, legal and professional considerations. The nurse is required to demonstrate a high level of competency and the ability to balance respect for the patient's values, autonomous rights, freedoms and choices with the most beneficial and health-enhancing approach to improve the health and welfare of the patient (NMC 2015, pp. 4–6). No course of action taken by a healthcare practitioner should compromise a patient's healthcare status, hence nurses must always base their decisions on the grounds of evidence and ethical, legal and professional foundations. Carvalho et al. (2012) emphasise that 'nurses have their clinical practice firmly rooted to the legal, ethical and professional foundations of education and training'. Therefore, it is paramount that I continue to familiarise myself with legal, ethical and professional frameworks related to mental health nursing, as they guide decision-making procedures (Carvalho et al. 2011). I have come to understand that any judgement following a risk assessment is very challenging and, to some extent, subjective. That is why it is good practice for such decisions to be made after a discussion with the care team, the patient and others involved with the patient's care.

References

- Barker, P. (2009) *Psychiatric and Mental Health Nursing. The craft of caring*. 2nd ed. London: Hodder Arnold
- Beauchamp, T.L. and Childress, J.F. (2001) *Principles of Biomedical Ethics*. 5th Ed. [Online] New York: Oxford University Press. Available from: <<http://books.google.co.uk/books?>> [Accessed: 12.02.2016]
- Beauchamp, T.L and Childress, J.F. (2012) *Principles of Biomedical Ethics*, 7th Ed. Oxford.

- Bindman, J. Maingay, S. and Szmukler (2003) *The Human Rights Act and mental health legislation*. [Online] The British Journal of Psychiatry. 182 (2):91-94
Available from: <<http://bjp.rcpsych.org/content/182/2/91>> [Accessed 26.02.2016]
- Buka, P (2008) *Patients' Rights, Law and Ethics for Nurses*. A practical guide. London: Hodder Arnold
- Carvalho, S. Reeves, M. Offord, J. (2011) *Fundamental aspects of Legal, Ethical, and Profession Issues in Nursing*. 2nd Ed. London
- Castle, D. and Bassett, D. (2010) *A primer of clinical psychiatry*. Churchill Livingstone. Elsevier. Australia.
- CQC Care Quality Commission. (2015) *Regulation 20: Duty of candour. Information for all providers* [Online]. Available from: <<http://www.cqc.org.uk>> [accessed 12.02.2016]
- DOH Department of Health. (1983) *Mental Health Act 1983/amended 2007: code of practice* [Online]. Available from: <<http://qna.files.parliament.uk/ws-attachment>> [accessed 20.02.2016]
- DOH Department of Health. (2009) *Reference guide to consent for examination or treatment*. 2nd Ed. [Online]. Available from: <<https://www.dh.gov.uk/publications>> [accessed 17.02.2016]
- Driscoll, J. (2010) *What is reflective practice... and how might it contribute to your profession practice? A1 Day workshop Tuesday 8th January 2010* [Online]. Available from: <<http://supervisionandcoaching.com/>> [accessed 29.02.2016]
- Driscoll, J (2007). *Practising Clinical Supervision. A reflective approach for healthcare professionals*. 2nd Ed. Elsevier. London

HM Government (2005) *Mental Capacity Act 2005. Code of Practice*. [Online]. Available from: <http://www.gov.uk/government> [Accessed 05.02.2016]

Hughes, S. (2012) *History taking and risk assessment and mental state examination*. Resource pack. Academic Unit of psychiatry. Bristol

House of the Lords. (2007) Post-legislative scrutiny of the Mental Health Act 2007. First report of session 2013-2014. [Online]. Available from: <http://publications-parliament.uk> [accessed 19.02.2016]

NMC Nursing and Midwifery Council (2015) *The Code: for professional standards of practice and behavior for nurses and midwives*. London NMC. Stepheson, J. (2014) *NHS England to rollout "6C's" nursing values to all service staff*. [Online]. Nurse Manager. Available from: <http://nursing.net/roles> [accessed 15.02.2016]

Simpson, O. (2010) *Consent and assessment of capacity to decide or refuse treatment*. [Online] British Journal of Nursing, 20(8): 510-513. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/21537284> [Accessed 25.02.2016]

Taylor, H. (2013) *Consent to treatment part 2: what does consent mean in clinical practice?* [Online] Nursing Times. 109 (44).30-32.

Available from: <http://www.nursingtimes.net> [Accessed 17.02.2016]

Thomas and Moore, G. (2013) *Medical-Legal issues in agitated patient: cases and caveats*. [Online] West J. Emerg. Med.

Available from: <http://ncbi.nlm.nih.gov/pmc> [accessed 12.02.2016]

University of Salford. Available from: <www. Supervisionandcoaching.com> [accessed 27.02.2016]

Yeandle, J. Gordon, C. Challis. Fawkes, L. (2012) *Risk Assessment and Management of people with personality disorders*. [Online]. Art and Science. Self-harm. Mental Health Practice. 17(2).21. Available from: <///pdc-connection.ebscohost.com/> [accessed 17.02.2016]